Transitional Care Management Medicare FAQ

1. **As a Care Manager, patients must be called within 2 days after discharge? Does medication reconciliation need to done at that time?**
   - Obtain and review discharge information, medication reconciliation should be included on the discharge summary or continuity of care documents and should be documented in the patient's EMR

2. **Can you bill for ER or urgent care or just for hospital admission?**

   - TCM services are furnished following the beneficiary's discharge from one of these inpatient hospital settings:

     - Inpatient Acute Care Hospital
     - Inpatient Psychiatric Hospital
     - Long Term Care Hospital
     - Skilled Nursing Facility
     - Inpatient Rehabilitation Facility
     - Hospital outpatient observation or partial hospitalization
     - Partial hospitalization at a Community Mental Health Center

3. **If the patient is reached via telephone within the 2 business days but refuses to make a face-to-face -appointment can the phone call be billed?**
   - For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. If you make two or more separate attempts in a timely manner and document them in the medical record but are unsuccessful, and if all other TCM criteria are met, you may report the service. We emphasize, however, that we expect attempts to communicate to continue until they are successful. You cannot bill TCM if the face-to-face visit is not furnished within the required timeframe

4. **What exactly is meant by the TCM period?**
   - The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the date of the required face-to-face visit. You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period.

5. **I was under the impression that we had to make contact with as many patients as possible for TCM services and getting those patients in for TCM appointments with physicians within 1-2 weeks, but now you're saying that not every patient or appointment requires this. I feel like we weren't really allowed to triage these patients, but based on what you are saying it seems as though we can. Can you please clarify? Thank you!**
   - You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed. Clinical staff under your direction may provide certain non-face-to-face services.
     - Physicians or NPPs may furnish these non-face-to-face services:

       1. Obtain and review discharge information (for example, discharge summary or continuity of care documents)

2. Review need for or follow-up on pending diagnostic tests and treatments
3. Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems
4. Provide education to the beneficiary, family, guardian, and/or caregiver
5. Establish or re-establish referrals and arrange for needed community resources
6. Assist in scheduling required follow-up with community providers and services

- Clinical staff under your direction may provide these services, subject to the supervision, applicable State law, and other rules discussed above:
  1. Communicate with agencies and community services the beneficiary uses
  2. Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
  3. Assess and support treatment regimen adherence and medication management
  4. Identify available community and health resources
  5. Assist the beneficiary and/or family in accessing needed care and services

- You must furnish one face-to-face visit within certain timeframes as described by the following two Current Procedural Terminology (CPT) codes:
  - CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
  - CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)
    - The face-to-face visit is part of the TCM service, and you should not report it separately.

6. Can an MA make contact initially? Or does an RN have to make the first contact?

- It can be made by you or clinical staff who has the capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.

7. So can an RN care manager bill the 99495 or 99496 code?

- These health care professionals may furnish TCM services:
  - Physicians (any specialty)
  - These non-physician practitioners (NPPs) who are legally authorized and qualified to provide the services in the State in which they are furnished
  - Certified nurse-midwives (CNMs)
  - Clinical nurse specialists (CNSs)
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)

8. Doesn't the TCM requirements state a licensed medical professional has to be the one to do the phone follow up within 2 business days? Not just any clinical staff...

- It can be made by you or clinical staff who has the capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.

9. You may have covered this, Can anyone make the initial contact and does that contact have to be documented (besides being present in the doctors note)

- Yes, document the call.

10. Can all Medicare and Medicare Advantage plans be billed for CCM and transition codes?

- CCM could be billed to the MPFS during the same calendar month as TCM only if the TCM service period ends before the end of a given calendar month, at least 20 minutes of

qualifying CCM services are subsequently provided during that month, and all other CCM billing requirements are met. However we expect that the majority of the time, CCM and TCM will not be billed during the same calendar month.

11. **If we make the 2 or more timely attempts to do transition contacts unsuccessfully we can bill for TCM code even if they don't come in for a face-to-face?**
    - For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. If you make two or more separate attempts in a timely manner and document them in the medical record but are unsuccessful, and if all other TCM criteria are met, you may report the service. We emphasize, however, that we expect attempts to communicate to continue until they are successful. You cannot bill TCM if the face-to-face visit is not furnished within the required timeframe

12. **Could you expand on "attempts to communicate with patient should continue after the 1st 2 days until successful contact is made?"**
    - As above. For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. If you make two or more separate attempts in a timely manner and document them in the medical record but are unsuccessful, and if all other TCM criteria are met, you may report the service. We emphasize, however, that we expect attempts to communicate to continue until they are successful. You cannot bill TCM if the face-to-face visit is not furnished within the required timeframe

13. **If the TCM face-to-face is not performed but 2 attempts to reach the patient are performed and documented within 30 days, can my office bill for the 2 telephonic attempts? As above**
    - As above. For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. If you make two or more separate attempts in a timely manner and document them in the medical record but are unsuccessful, and if all other TCM criteria are met, you may report the service. We emphasize, however, that we expect attempts to communicate to continue until they are successful. You cannot bill TCM if the face-to-face visit is not furnished within the required timeframe

14. **Do the non-face-to-face transitional care management services include transition of care phone calls from the care manager?**
    - Yes, see #5 above.

15. **To clarify I can bill 98966 if patient does not come in for f/u appointment? if patient comes in I can bill 98966?**
    - If patient comes in and you bill 99496: Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge (do not report 90951–90970, 98960–98962, 98966–98969, 99071, 99078, 99080, 99090, 99091, 99339, 99340, 99358, 99359, 99363, 99364, 99366–99368, 99374–99380, 99441–99444, 99487–99489, 99605–99607 when performed during the service time of codes 99495 or 99496).

16. **A patient is released from the hospital to home on 5/1/17. I call them to do a TOC on 5/2/17, but they do not make an appointment. Do I bill a 98966?**

- Medical Necessity/Documentation Requirements to bill 98966:
- If you decide to bill for these services, the following criteria should be met:
    - Service is personally performed and reported only for established patients.
    - The call must be initiated by an established patient.
    - If the patient is a minor, the episode of care must be initiated by a guardian/parent.
    - These are time-based codes. The length of the telephone call must be documented, in addition to the nature of the service and other pertinent information, in the medical record.
    - If the telephone service relates to and takes place within a postoperative period, the service is considered part of the procedure and not separately reportable.
    - The telephone encounter cannot be related to an E/M service performed and reported by the physician or qualified nonphysician health care professional within the previous seven (7) days.
    - If the telephone call ends with a decision to see the patient within 24 hours or the next available urgent appointment, the telephone encounter is considered part of the pre-service work of the subsequent E/M service, procedure and visit.
    - Telephone services cannot be reported with Care Plan Oversight CPT Codes: 99339-99340 and 99374-99380, nor Anticoagulation Management CPT Codes: 99363 – 99364.
    - Providers must meet every part of the CPT definition and there must be documentation in the medical record to support the services.
    - These services are a non-covered service by Medicare and delivery of an Advance Beneficiary Notice of Noncoverage (ABN) is not required.

17. We have to wait 30 days post discharge before billing? We were informed we could bill immediately following the face-to-face component of the TCM.

- The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the date of the required face-to-face visit. You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period.

18. Can telephonic codes be used at the same time as TCM codes?

- Telephone calls are included in the TCM code that is billed, no additional codes are required. Please refer to the list of codes not allowed to be used during the TCM service period.

19. Are CCM codes billable after the face-to-face with the provider?

- Questions regarding CCM will be answered during June's webinar
- Cannot be billed in conjunction with TCM

20. What requirements are there for signatures on Care Management notes? Does provider need to sign-off on every interaction?

- A supervising physician counter signature is required after a nurse practitioner documentation/signature that work incident to a supervising physician.
- A supervising physician counter signature is not required for a nurse practitioner that has his/her own NPI (provider number) working within the scope of their practice under state laws as an independent nurse practitioner. Most states require a counter signature by a supervising physician for physician assistant services. Physician assistants are encouraged to refer to state laws and regulations governing he scope of practice.

21. If you have met all TCM requirements but patient is readmitted after face-to-face visit but within the 30 day period can you still bill the TCM code?

- TCM codes are only billed one time during the 30 day period. If the patient is re-admitted during that initial 30 days, you cannot bill the code again.

22. Who determines if TCM is medically necessary and needed?

- Typically, it is a provider's decision as to whether or not patient may need TCM

23. Do RN home visits constitute face-to-face visits?

- Face-to-face visits can be performed anywhere but it needs to be performed by a qualified provider with appropriate supervision. Please refer to the list of approved providers.
    - RNs are not able to furnish TCM services